MHA Nation Infant and Toddler Program
404 Frontage Rd.
New Town, ND 58763
Office: (701) 627-2458 / Fax: (701) 627-2365

Enrollment Application

For Office Use Only	
Entered Stamp:	Child Plus: _____ ASQ: _____ Brigance: _____ Technician: _____

Child Information (All boxes are Required to be filled out)	
First & Last Name:	
Gender: Male or Female	**DOB:**
Birth Weight:	**Weeks Premature:**
Residing Segment:	**Ethnicity:**
Enrolled member of a Federally Recognized Tribe? YES or NO **Tribal Affiliation: _____** **Enrollment Number: _____**	**Is Child Adopted? YES or NO** **Is child currently in foster care? YES or NO** **List Case Manager: _____**
Referral Source:	**Health Insurance:**

Will need proof of Health Insurance (if any) & Tribal Enrollment

Parent/Guardian Information	
First & Last Name:	
First & Last Name:	
Mailing Address:	
Physical Address:	
Phone #:	**Phone #:**
Best Time to Contact:	
Email:	

Early Intervention Specialist Review Initials: _____

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Family Information (Please Circle any that apply):			
TANF	**Medicaid**	**EBT/Commodities**	**General Assistance**
WIC	**First Steps**	**Indian Health Services**	**Other:**
Occupation Status: **_____Employed** **_____Unemployed**		**Highest Level of Education:** **___ Grade ___HS or GED ___2YR___4YR___Grad/PhD**	

Please check any that apply:

___ Teen Parent
___ Baby born with a positive toxic screen (Drugs)
___ Child with a disability
___ Chronic health condition
___ Low educational attainment
___ Low Income (Eligible for WIC, Food Stamps, TANF, Fuel Assistance, GA, ETC.)
___ Recent Immigrant or refugee family (Foreign Born)
___ Substance Abuse (Parent had used or currently using illegal substances)
___ Court Appointed legal guardians and/or foster parents
___ Homeless or unstable housing
___ Incarcerated Parents
___ Very low birth weight (under 3.3 lbs.)
___ Death in immediate family (a child, parent, or sibling)
___ Domestic Violence
___ Child abuse or neglect
___ Military Family
___ On Individual Education Plan (IEP) of Individual Family Service Plan (IFSP) Where?
___ Receiving Financial Assistance from any other Tribal or Federal funded program for appointments.

Media Release

I am giving consent for photographs, videos and/or like materials, in which my son/daughter may appear – to be used in any promotion materials.
Initials: _____

Exchangeable and Release of Information

I am giving permission for the Infant & Toddler Program my son/daughter is enrolled in to share and or exchange information with the staff of the Infant & Toddler Program and TAT Head Start.
Initials: _____

_____ _____
Parent/Guardian Signature **Date**

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Screening Notice & Consent

With your permission, the Infant & Toddler Program will conduct a developmental screening to determine any concerns or needs with your child's development. A need for further evaluation may be determined as a result.

Would you like to receive a text /email of your child's next screen? YES or NO

The **ASQ** and **Brigance** screening covers:

Gross Motor Skills	Fine Motor Skills
Visual Motor Skills	Receptive Language Skills
Expressive Language Skills	Self – Help Skills
Social & Emotional Skills	Speech & Language Skills

Other forms of screenings (please circle). *By request are:*

Hearing & Vision	Autism	Behavioral Health

I hereby authorize the Infant & Toddler Program to screen my child.

Child's Name:	Date of Birth:

Parent/Guardian Signature **Date**

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Authorization for Release of Information

As the legal parent/guardian of: _____ who's birthdate is: __/__/__. I hereby authorize the Infant & Toddler Program under the Three Affiliated Tribes to exchange verbal and written information related to evaluations, programming, health records, and developmental progress with the following agencies who may be working with my child.

Anne Carlson Center – Jamestown, ND
BECEP – Bismarck, ND
Chatter Pediatric Therapy – Williston, ND
Division of Children's Special Health Services – Bismarck, ND
Elbowoods Memorial Healthcare – New Town, ND
KIDS Human Service Center – Dickinson, ND
Mayo Clinic – Rochester, ND
Minot Center of Pediatrics – Minot, ND
Minot Infant Development – Minot, ND
Northwest Human Service Unit – Infant Development – Williston, ND
Red Door Pediatric Therapy – Bismarck & Minot, ND
Rehab Visions – Dickinson, ND
Sanford – Bismarck, ND
Shriner's Children Hospital – Chicago, IL
Souris Valley Special Services – Minot, ND
St. Alexius – Bismarck, ND
TAT Head Start, WIC, Social Services – New Town, ND
Trinity Hospital – Minot, ND
West Central Human Services – Bismarck, ND
West River Special Services – Dickinson, ND
Wilmac Service Unit – Williston, ND

Other: _____

I, the legal parent/guardian of the child listed above, understands that information will be only used to assist the team(s) in developing and implementing and appropriate program for developmental activities and family support services. This may be withdrawn with a written consent at any time. The authorization to release information will last until the day the child turns six years of age or moves from the Fort Berthold Indian Reservation.

_____ _____
Parent/Guardian Signature **Date**

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The information you provide will help us connect you with the appropriate resources for your child if needed.

Please check the appropriate box I your child has been identified or is suspected of having any of the following:

	Identified:	Suspected:	Date:	Evaluated by:
Intellectual Disability				
Hearing Impairments				
Vision Impairments				
Speech/Language Impairments				
Emotional / Behavior Disorder				
Specific Learning Disabilities				
Deaf or Blindness				
Autism				
Traumatic Brain Injury				
Developmental Delay				
Other Health Impairments				
Allergies				

Please check box if parent/guardian reports no disability at this time.

☐

Parent/Guardian Signature _____ **Date** _____

Early Intervention Specialist Review Initials: _____

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